Vision Service Plan

Enrollment Form

Group Name: City of Alameda		Effective Date:	
Employee Info	Social Security No.	Sex (M/F)	Date of Birth
	Last Name	First Name	Middle Initial
	Address	City	State Zip

Coverage Info	Check Box to indicate desired coverage	2016 Monthly Vision Rates	
	☐	Single	$ 7.40
	☐	Two Party	$ 14.30
	☐	Family	$ 22.70

Add/ Delete	Dependent Info	Last Name	First Name	Middle Initial	Sex (M/F)	Date of Birth
	Spouse					
	Child					

I authorize the City of Alameda to deduct the VSP premium (including any future increases) from my wages.

_____ _____

Employee Signature Date

Return completed form to Human Resources